FAMILY MEDICAL PRACTICE

Susan M. Nasser, D.O.

New Patient Registration Forms Packet

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- ✓ Insurance Information
- ✓ Assignment & Release
- ✓ Physician-Patient Arbitration Agreement
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- ✓ HIPAA Protected Health Information
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familyfirst Family Medical Practice
42135 10th Street W., Suite 201
Lancaster, CA 93534
661-341-3800, Fax 661-341-3810

familyfirst FAMILY MEDICAL PRACTICE

Susan M. Nasser, D.O.

Patient Information

Date ____________________ Home Phone ______________________ Cell Phone ___________________

Name ____ Sex ❑ M ❑ F Age ___ Date of Birth __________

Address _____________________________________ City_____________________ State ____ Zip _____

Employer __________________________ Occupation______________ Drivers License #_______________

Email __________________________ Primary Treating Physician/Family Physician? _________________

In case of emergency, who should be notified? ________________________________ Phone ___________

Race ___________________ Ethnicity ___________________ Preferred Language ___________________

Preferred method of contact ❑ Mail ❑ Web Message

Insurance Information: Is this a Workers Compensation Claim? ❑ No ❑ Yes

Primary Insurance _____________________________ ID # _____________________ Group #__________

Subscriber Name_____________________________________ Relationship to patient _________________

Cardholder Date of Birth ______________________ Drivers License #______________________________

Secondary Insurance _________________________ ID # _______________ Group #_________________

Subscriber Name _____________________________________ Relationship to patient ________________

Cardholder Date of Birth ______________________ Drivers License #______________________________

Assignment & Release

I certify that I and/or my dependent(s) have insurance coverage with the above insurance listed and assign directly to **Family First Medical Group** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I will be responsible for all collection/attorney fees if my account becomes delinquent. I authorize the use of my signature on all insurance submissions. The above-named physician may use my healthcare information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This release is valid until I notify the practice in writing with any changes.

____ ________________________
Signature of patient, guardian or legal representative Date

____ ________________________
Printed name of patient, guardian or legal representative Relationship to patient

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Physician-Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intension of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services. ____

Patient's or Patient Representative's initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledgement that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: **familyfirst Family Medical Practice** _____________
Date

By: ____________________________________ _______________
Patient's or Patient Representative's Signature Date

By: ____
Print Patient's Name

____
Print or Stamp Name of Physician, Medical Group, or Association Name

____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

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Payment Policy

We appreciate your confidence in our practice and we look forward to participating in your care. We realize that most medical problems are not foreseen; therefore, we wish to advise you of our payment policy.

1. We will file all insurance for your care. You will be responsible for all co-pays, co-insurance and deductibles at the time of visit.

2. All self pay patients will be expected to pay in full on their first visit.

3. All self pay patients and any patient with an outstanding balance over $250 will be required to apply for CareCredit prior to any payment arrangements being set up. You may elect not to apply for CareCredit, however, you will be responsible for all payments due at the time of service.

4. All self pay patients will be required to pay for elective surgery prior to surgery.

5. We will submit to all patients (2) statements of current patient balances by mail. If we receive no response to these statements, we will begin the collection process immediately. If your account is sent to an outside collection agency, you will be responsible for all collection and legal fees.

6. We encourage you to stay in contact with our office regarding financial issues, as we will attempt to work with you.

7. We accept MasterCard, Visa, American Express, Cash, Check and CareCredit.

8. Returned Check fee is $25.

9. If you cancel your appointment in less than 24 hours or ‘No Show’ for an appointment, you may incur a $25 fee.

I have read and understand the above payment policy.

______________________________ ______________________________
Patient’s Name Account #

______________________________ ______________________________
Signature of Patient/Guardian Date

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Covered CA and Narrow Network Policy

This letter is to educate our patients in the way that your new insurance or your new insurance policy will affect you in our office. **These changes will only affect Anthem Blue Cross and Blue Shield of CA patients.** Although our office is still in-network with “some” of the Blue Cross and Blue Shield plans, we are not in-network with the new Covered CA plans and the Narrow Network plans they are offering.

For our Anthem Blue Cross Covered CA or Narrow Network patients, unfortunately at this time our office will “not” be able to accept insurance or schedule appointments at this time. The reason that we will be unable to see patients at this time is because currently the Blue Cross’ system is unreliable in providing accurate information regarding whether or not a plan is a PPO or an EPO. As a result we are seeing patients who should have out-of-network benefits with a PPO plan, but do not because their plan is truly an EPO. This is causing an unexpected cost to patients that they may not be prepared for. Blue Cross is also inconsistent with the labeling of their insurance ID cards, showing whether or not the plan is a Covered CA plan or a Narrow Network plan. Since we currently cannot rely on the information they are producing and we are not in-network with their new Covered CA and Narrow Network plans, we will “not” be seeing patients with these plans.

For our Blue Shield Covered CA and Narrow Network patients, we will be able to accept your insurance at this time, however, you will be charged for what Blue Shield allows for a service at the time of your visit. You will be charged the rate that our current contract with Blue Shield allows and not the 30% fee reduction that the new Covered CA and Narrow Network plans allow. The reason for this is because Blue Shield is processing our claims as out-of-network and mailing the payments to the subscriber of the insurance. If you want an explanation as to what your out-of-network benefits are, you should contact your insurance for the most accurate explanation.

familyfirst Family Medical Practice apologizes for any inconvenience that this is causing you, but in order to provide the highest level of care without compromising patient care both physically and financially, this is the policy that we have to implement at this time.

If you have any other questions regarding this policy, you may speak with the billing department for further explanation. Thank you for your understanding and patience during this transition period.

Patient Name ______________________ Signature ______________________

Date ______________________

HIPAA Protected Health Information

In general the Health Information Patient Accountability Act (HIPAA) privacy rule gives individuals the right to request a restriction on use or disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

This office will generally contact patients by written communication or phone calls. We will send letters or call the number the patient has provided on the Patient Information sheet.

Please verify your phone numbers and complete the following:

Home Telephone (______) __________- ____________________
❑ Okay to leave message with detailed information.
❑ Leave message with call-back number only.

Cellular Telephone (______) __________- ____________________
❑ Okay to leave message with detailed information.
❑ Leave message with call-back number only.

Work Telephone (______) __________- ____________________
❑ Okay to leave message with detailed information.
❑ Leave message with call-back number only.
❑ Okay to fax to (______) __________- ____________________.

Written Communication (______) __________- ____________________
❑ Okay to mail to my home address:
____
____

❑ Please mail to another address
____
____

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply for use or disclosures made pursuant to any authorization requests by the individual.

Record of Disclosures of Protected Health Information

I, ____, authorize the office of **familyfirst Family Medical Practice** to contact the following person(s) in regard to my medical information.

______________________________ ______________________________
Name/Relationship Telephone Number

______________________________ ______________________________
Name/Relationship Telephone Number

______________________________ ______________________________
Patient Name/Date of Birth Patient Signature

Today's Date: ______________________________________

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Notice of Privacy Practices Acknowledgment

❑ I wish to receive a copy of the Notice of Privacy Practices at the time of my signature below.

❑ I decline to receive a copy of the Notice of Privacy Practices at this time. I understand I can obtain a copy at any time per my request.

Name ______________________ Date of Birth ______________________

Signature ______________________ Date ______________________

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Health History Questionnaire

Patient's Name ______________________________ Today's Date ____________

Date of Birth ____________ Age ________ Date of Last Physical Examination ____________

What is your reason for the visit? ______________________________

____

Symptoms check symptoms you currently have or have had in the past year

General
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweats

Muscle/Joint/Bone
Pain,weakness, numbness etc.
- ❑ Arms
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Neck
- ❑ Shoulders

Genito-Urinary
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

Gastrointestinal
- ❑ Appetite Poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excess thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal Bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

Cardiovascular
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

Eye/Ear/Nose/Throat
- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision

Eye/Ear/Nose/Throat
- ❑ Ear ache
- ❑ Ear discharge
- ❑ Hay Fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Persistent Cough
- ❑ Ringing in ears
- ❑ Sinus problem
- ❑ Vision flashes
- ❑ Vision halos

Skin
- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Scars
- ❑ Sore that will not heal

Men Only
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other

____
____
____

Women Only
- ❑ Abnormal pap smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

____
____
____

Date of last menstrual period:
____

Date of last pap smear:
____

Have you had a mammogram?
❑ Yes ❑ No

Are you pregnant?
❑ Yes ❑ No

Number of children ___

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Health History Questionnaire (continued)

Conditions check symptoms you currently have or have had in the past year

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorders
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High cholesterol
- ❑ HIV positive
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Measles
- ❑ Migraine headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate problem
- ❑ Psychiatric care
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid problems
- ❑ Tonsilitis
- ❑ Tuberculosis
- ❑ Thyroid fever
- ❑ Ulcers
- ❑ Vaginal infections
- ❑ Venereal disease

Medications list all medications you are currently taking

____

____

____

Allergies

____

____

____

Pharmacy Name ______________________________ Phone ______________________________

Family History fill in health information about your immediate family

Relation	**Age**	**State of Health**	**Age at Death**	**Cause of Death**
Father				
Mother				
Brothers				
Sisters				

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Health History Questionnaire (continued)

Family History

check if your blood relatives had any of the following

Disease	Relationship to You
Arthritis, gout	
Asthma, hay fever	
Cancer	
Chemical dependency	
Diabetes	
Heart disease, strokes	
High blood pressure	
Kidney disease	
Tuberculosis	
Other	

Have you ever had a blood transfusion? ❑ Yes ❑ No
If yes, please give dates ______________________

Serious Illness/Injuries

	Date / Outcome

Hospitalization

Year	Hospital	Reason for Hospitalization

Pregnancies

Year of Birth	Sex of Birth	Complications if any

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Health History Questionnaire (continued)

Health Habits check which you use and how much you use

- ❑ Caffeine ________________________________
- ❑ Tobacco ________________________________
- ❑ Street drugs ____________________________
- ❑ Other ________________________________
  ____

Occupational check if your work exposes you to

- ❑ Stress
- ❑ Heavy lifting
- ❑ Hazardous substances
- ❑ Other ________________________________
  ____

Occupation: ____________________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____ ____________________
Signature of Patient, Parent, Guardian, or Personal Representative Date

____ ____________________
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

____ ____________________
Reviewed By Date

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